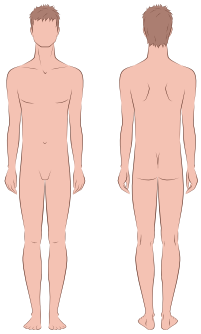
ORION PHYSICAL THERAPY | ACTIVE ORTHOPEDICS

Initial Questionnaire

NAME	DATE	THERAPIST



Date of injury/onset of symptoms: _____

What/where are your current symptoms? *Mark and describe:* _____

_____

_____

Which best describes how your injury/condition occurred:

- o lifting
- o a fall
- o degenerative process
- o during recreation/sports
- o cumulative trauma/overuse
- o other: _____
- o car accident
- o trauma
- o running
- o unknown

Where did your injury occur?

- o at work
- o auto
- o other premises _____
- o at home
- o unsure

Nature of symptoms:

- o sharp
- o aching
- o numbness
- o other_____
- o dull
- o tingling
- o throbbing

Frequency of symptoms:

o constant o intermittent o occasional

Describe: _____

State your pain level on a scale of 0 to 10:

(0 = no pain, 10 = hospitalized by pain)

At rest ____ / 10 With activity _____ / 10

At worst _____ / 10

Prior to this onset, have you experienced these symptoms in the past?

o Yes o No Explain: _____

_____

Have you had any operations on the body region associated with your present symptoms?

o No o Yes Date _____

Type of surgery_____

Does the pain wake you at night?

o No o Yes _____ times per night

Are your symptoms worse in the:

o morning? o afternoon? o evening?

Are your symptoms worse with:

o sitting? o standing? o walking?

What makes your symptoms worse?

Check all that apply.

- o sitting
- o standing
- o walking
- o squatting
- o lying down
- o vacuuming
- o stress
- o swallowing
- o chewing
- o sleeping
- o making the bed
- o going to/from sitting
- o reaching out/overhead
- o reaching behind back
- o looking overhead
- o going up/down stairs
- o coughing/sneezing
- o taking a deep breath
- o doing dishes
- o sustained bending
- o up/down an incline

o sports or recreational activities such as _____

_____

o other: _____

_____

Continued on back

Initial Questionnaire | Page 2

What relieves/lessens your symptoms?

- o sitting
- o exercise
- o standing
- o heat
- o lying down
- o ice
- o changing positions
- o nothing
- o rest
- o stretching
- o alcohol
- o massage
- o other: _____

What previous treatment have you had?

- o none
- o traction
- o injections
- o bracing/taping
- o massage therapy
- o manipulation/adjustments by an osteopath or chiropractor
- o medication
- o physical therapy
- o TENS unit
- o exercise
- o other_____

Have you had any of the following?

o x-rays o MRI o CT Scan o other

Date _____

Are you currently working?

o yes o no Occupation _____

o part time o full time o restricted duty

What positions are you in while working?

o standing o sitting o walking o bending

o lifting: _____lbs frequency _____

List any activities that you can't do now because of your injury/symptoms: _____

_____

_____

What goals would you like to achieve from therapy? _____

_____

_____

Have you had, or do you currently have any of the following medical conditions?

- o cancer
- o pregnant *(currently)*
- o heart disease
- o joint disease/arthritis
- o pacemaker
- o recent surgery *(this year)*
- o high blood pressure
- o joint replacement
- o diabetes
- o history of seizures
- o breathing difficulties
- o osteoporosis
- o other: _____

_____

Are you currently taking any prescription or over-the-counter medications? *(Please list)* _____

_____

_____

_____

_____

_____

_____

THERAPIST SIGNATURE DATE